ASMS ANNUAL REPORT 2016

ASMS 28TH ANNUAL CONFERENCE 2016

ASMS
TOI MATA HAUORA
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Helen Kelly

The Association was greatly saddened to lose a long-standing friend and advocate for working New Zealanders with the death of former Council of Trade Unions leader Helen Kelly in October 2016. During her eight years as CTU President, she was always supportive of Association activities and initiatives. She was a compassionate warrior who campaigned effectively and with great determination and heart to make people's working lives fairer, safer and better paid.

Helen Kelly spoke at the Association's 2015 Annual Conference about the role of unions as public institutions, which need to be valued for the work they do. Her speech made a lasting impression on delegates and she received a standing ovation.

Her legacy includes her focus on kindness, and how it forms the basis of all positive human interactions, including those between employers and employees.

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The major events and challenges since the 27th Annual Conference in November 2015 have been: national DHB MECA negotiations, the joint conference with New Zealand Medical Students Association on the specialist workforce in 2025, the survey on senior medical officer hours of work and burnout in district health boards and subsequent publication of results in a *Health Dialogue*, proposed changes to the funding model for vocational medical training, and initiatives to address workplace bullying and harassment.

The National Executive comprises:

President	Hein Stander (Tairawhiti)
Vice President	Julian Fuller (Waitemata)
Region 1	Jeannette McFarlane (Auckland) Carolyn Fowler (Counties Manukau)
Region 2	Jeff Hoskins (Waikato) Paul Wilson (Bay of Plenty)
Region 3	Tim Frendin (Hawke's Bay) Jeff Brown (MidCentral) – National Secretary
Region 4	Murray Barclay (Canterbury) Seton Henderson (Canterbury)

The National Executive will have met on seven occasions in Wellington since the last Annual Conference: 3-4 February, 14 April, 11 August, 1 September, 6 October (Executive only day) and 16 November.

On 3-4 February, the National Executive held its annual two-day meeting to discuss strategic directions for the year. The first informal day included:

- planning for the national DHB MECA negotiations
- session with Medical Council Chair Andrew Connolly
- relationship with NZ Medical Students Association
- session with Deputy Labour Leader and health spokesperson Annette King.

The National Executive was pleased to have Chai Chuah, Director-General of Health join them for a session at their September meeting.

Constitution

The National Executive has considered the historical and current makeup of the Executive and its functions. It has determined that a subcommittee should be established to examine the Constitution, including representation, the roles of the National Officers (President, Vice-President, Secretary) and any suggested changes that could be brought to the Annual Conference in 2017.

National Office

The national office has three more permanent staff than last year, now comprising 18 staff — Ian Powell (Executive Director), Angela Belich (Deputy Executive Director), Yvonne Desmond (Executive Officer), Cushla Managh (Director of Communications), Henry Stubbs (Senior Industrial Officer; part-time), Lloyd Woods (Senior Industrial Officer), Steve Hurring (Industrial Officer), Sarah Dalton (Industrial Officer), Dianne Vogel (Industrial Officer; commenced in February), Ian Weir-Smith (Industrial Officer; commenced in February), Lyndon Keene (Director of Policy & Research; part-time), Charlotte Chambers (Principal Analyst Policy & Research), Lauren Keegan (Assistant Executive Officer), Sharlene Lawrence (Office Manager; commenced in June), Kathy Eaden (Membership Support Officer; part-time), Maria Cordalis (Administration Officer - Membership) and Lydia Schumacher (Administration Officer - Communications; commenced in January). We engage additional support on a weekly basis to assist with financial accounting and reporting from Grant Thornton Ltd.

Lyn Hughes, who commenced employment with the Association as an Industrial Officer in May 2008, and was promoted to Senior Industrial Officer in February 2015, resigned in July 2016. The Association is appreciative of the high quality of her work and the significant contribution she made to the representation we provide to our members. Her vacant position is expected to be advertised early next year.

In the early years the Association's had a small number of office staff who functioned with high trust and informal processes. This has worked well but with the significant expansion in national office numbers and roles in recent years, some adaptation is required. The staff have begun coordination sessions when all teams get together. One of these sessions, in July, included a session with Dr Michael Macaulay (Director, Institute for Governance & Policy Studies and Associate Professor, Public Management) on 'integrity management'. The initiative came from Senior Industrial Officer Lloyd Woods who, earlier this year, graduated with the Masterate of Public Policy at Victoria University. His study included time with Dr Macaulay.

Integrity management is an academic field that is evolving into a management philosophy to help organisations conduct business, even in the most challenging of markets, without compromising their ethics. It enables organisations to go beyond merely abiding by the law, to taking a voluntary, proactive approach to ensure its activities promote responsible behaviour, with fairness, sustainability, and cultural sensitivity in the communities in which they operate.

Lloyd Woods and Executive Officer Yvonne Desmond prepared advice to the Executive Director on implementing integrity management, and the latter has undertaken a 'sabbatical' of nearly three months from July to October to research and prepare a report. Assistant Executive Officer Lauren Keegan acted in her role during this period.

The sabbatical also covered 'events management' and office systems, including information technology. It included a trip to Europe to meet with a range of relevant organisations beginning with Marburger Bund (both the federal and Berlin regional offices), meetings in England including Medical Protection Society (both the London and Leeds office) and the Unison public sector union, the Irish Hospital Consultants Association and Irish Medical Organisation in Dublin. In New Zealand she has visited Medical Assurance Society, Grant Thornton Ltd and E tū, the largest private sector union. She is now writing the report with Lloyd Woods.

Preparation for national DHB MECA negotiations

The current multi-employer collective agreement (MECA) expired on 30 June 2016, although it continues in force (including for new appointees) until a replacement is negotiated. As advised in last

year's Annual Report, the National Executive had determined to have a larger, more diverse negotiating team, including medical officers, along with a broader range of claims.

The negotiation team comprises:

- Executive Director Ian Powell as advocate, supported by Deputy Executive Director Angela Belich.
- All 10 National Executive members
- Ian Page, Northland (obstetrics & gynaecology)
- Jonathan Casement, Waitemata (intensivist and anaesthesia)
- Julie Prior, Waitemata (emergency medicine medical officer)
- Brigid Connor, Auckland (radiology)
- Julian Vyas, Auckland (paediatrics)
- Willem van der Merwe, Auckland (emergency medicine medical officer)
- Helen Frith, Counties Manukau (anaesthesia)
- Angela Freschini, Tairawhiti (anaesthesia)
- Kai Haidekker, Hawke's Bay (radiology)
- Neil Stephen, Hutt Valley (dentistry)
- Justin Barry-Walsh, Capital & Coast (psychiatry)
- Sinead Donnelly, Capital & Coast (palliative medicine)
- Andrew Munro, Nelson Marlborough (emergency medicine)
- Prieur du Plessis, Nelson Marlborough (orthopaedic medical officer)
- Anja Werno, Canterbury (microbiology)
- Matthew Hills, South Canterbury (medicine)
- Tim Mackay, Southern (dentistry).

Under the theme of *achieving patient centred care,* as endorsed by Annual Conference last year, the next step was to develop our claim for the negotiations. The Executive Director presented a draft claim for consideration by the National Executive at its February meeting. Refinements were made to that draft which was further considered at a one-day workshop in April by the full negotiating team. This led to further minor amendments that were approved by the Executive the following week.

Majority of the ASMS MECA negotiating team (several members are absent).

The Executive Director, Deputy Executive Director and Senior Industrial Officer Lloyd Woods also represented the Association in negotiations with DHB representatives over a 'bargaining process agreement' (a requirement under the Employment Relations Act). This was agreed amicably within one day.

Formal negotiations commenced on 5 and 6 May. In total, there have been 11 days of negotiations, the last on 30 September. Negotiations are currently adjourned pending consideration of an offer for settlement by Annual Conference. The Association's ratification process is that the National Executive will take into consideration the results of a secret membership ballot. Considering the nature, limitations and timing of the DHB offer, the negotiating team believes it appropriate to first refer the offer for consideration by Conference.

The DHBs' negotiating team comprises two advocates from their shared services agency (DHBSS), one chief operating officer, three human resource managers, and another three senior managers. They report immediately to the Chair of the DHBs Employment Relations Strategy Group, Whanganui DHB Chief Executive Julie Patterson. Another key player is Lakes DHB Chief Executive Ron Dunham in his capacity as Chair of the chief executives national group. Ultimately, responsibility rests with the chief executives.

Negotiations have been difficult and at times there has been tension between the parties. There has been progress although very limited (for example, claims on recovery time, employee well-being, and extending the locum clause to resident medical officer vacancies), but not over any claim that involves financial costs.

The central difficulty has been the chief executives' distaste for genuine negotiations. They have determined in advance how much funding they are prepared to allocate for this settlement and, with restrictions, confined negotiations to how this allocation is to be disbursed. The allocation for a three-year term is an annual ongoing cost of $230 million. That is, in their view, the increased annual costs of the new MECA must not exceed this limit by the time of the expiry date of the new agreement.

They are also seeking to impose further restrictions. These involve matters where the DHBs believe the MECA may contradict what they believe the 'industry standard' should be. This is primarily around the rate of remuneration for hours worked on after-hours rosters and shifts. The precise hours to which any increased rate would apply would have to be consistent with their view on the 'industry standard'.

Underpinning their approach is a view that senior medical staff are fundamentally the same as other parts of the DHBs' workforce and should be treated no differently, and that the specific labour market for senior medical staff is the same as for other professionals, trades and groups employed by DHBs.

Prior to the commencement of negotiations, the Association was advised that the DHBs would not be pursuing claims that would be clawbacks (loss of existing entitlements and rights). However, this has proven not to be the case. The following clawbacks have been attempted:

1. Embarking on a particular process that could lead to the loss of job sizing and its associated rights and protections. This has been withdrawn.
2. Embarking on a particular process that could lead to the loss of one week's annual leave and the relatively open-ended sick leave entitlement. This has been withdrawn.
3. Shifting the discretion for time-in-lieu for CME undertaken on a weekend from the employee to the employer.
4. Proposing an additional specialist step but then taking away the value of it for those who already have additional conditions above this rate, such as those in clinical leadership positions.

They are also seeking to remove two weeks paid parental leave for partners, although this is linked to increasing the entitlement for the primary care giver.

The DHBs also attempted to go around the ASMS negotiating team when chief executives Ron Dunham and Julie Patterson inappropriately wrote to the National President seeking to influence our approach. This was firmly rebutted by Dr Stander.

The DHBs' offer for settlement will be a major subject for discussion at Annual Conference. The outcome of this discussion will shape the further direction of negotiations. It may be necessary for delegates to consider a gradual escalation of the Association's approach.

RMO strike: payments for senior medical officers undertaking additional duties

As a consequence of a deterioration in the negotiations with the DHBs over the resident doctors MECA, the Resident Doctors Association held a 48-hour strike commencing 0700h 18 October. This was the first RMO strike since April 2008. At that time ASMS and the DHBs had negotiated special rates for additional duties undertaken by senior medical officers as a consequence of the strike.

Endeavours to reach agreement for the 2016 RDA strike proved unsuccessful due to highly questionable conduct by the DHBs, influenced by the continued distaste of the chief executives toward collective negotiations. As an opening position the Association sought the 2008 rates inflation adjusted, whereas the DHBs sought to reduce the 2008 rates by between 28% and 33%. The Association advised that we were prepared to agree to a compromise between the actual and inflation-adjusted 2008 rates.

However, along with underhand conduct by their representatives, the chief executives abandoned negotiations with the Association for a national agreement and unilaterally decided a divisive range of rates (between the 2008 rates reduced by up to 33% and the actual 2008 rates) leaving it for each chief executive to determine. Further, the Chair of the chief executives national group forwarded a misleading and inflammatory circular for chief executives to, in turn, forward to all DHB-employed senior medical staff. This represented major disrespect for senior medical staff and increased anxiety and uncertainty leading into the strike. Significantly, several chief executives decided against forwarding the offending circular and also did not adhere to the range of rates approach.

The Association was left with no option but to forward to all DHB-employed members our assessment of what had occurred, including the questionable conduct, and recommended the 2008 inflation-adjusted rates. We are now involved in advising and supporting members as well as discussions with individual DHBs. If further strikes are called and the chief executives continue with their hard-line position, the situation will only worsen and relationships will deteriorate further.

Medical Students Association and joint conference

Since 2014 the Association and the New Zealand Medical Students Association (NZMSA) have been developing a closer working relationship. This began by us helping fund NZMSA to send observers to our 2014 Annual Conference, which was repeated last year.

An achievement of this relationship was the holding of a joint conference in Wellington on 1 April on the training of specialists for 2025. At its February meeting, the National Executive resolved to pay $5,000 toward the costs of NZMSA delegates attending this conference, and to meet the costs for catering and audio-visual requirements.

The conference was co-convened by former Resident Doctors Association and NZMSA Presidents Drs Curtis Walker and Marise Stuart. It was attended by 124 members, medical students and other invitees. The keynote speakers were:

- Andrew Connolly, Medical Council Chair and Counties Manukau DHB general surgeon, on the type of specialists New Zealand will need for 2025.
- Peter Frampton, University of Otago Medical School Dean, on training specialists for 2025.
- Lyndon Keene, Association Director of Policy & Research, on the health system in 2025.

The National Executive was pleased with the conference. Arising out of this event, the two associations developed an agreed communique on the conference theme which was released in late October. It has been widely distributed including to our respective memberships, DHBs, professional colleges, Government, and other stakeholders. It will also become an agenda item for our Joint Consultation Committees.

The Executive also agreed to become a bronze sponsor ($9,000 plus GST) for NZMSA's annual conference in Dunedin on 23-25 April and to again financially support NZMSA attendance at the 2016 Annual Conference. The Executive Director gave a presentation to the NZMSA clinical leadership forum held immediately after the joint conference.

The two associations are currently discussing the application of this increasingly valuable relationship for next year.

Life membership

At its April meeting, the National Executive voted unanimously to recommend to Annual Conference that Dr David Jones become the Association's seventh life member. Dr Jones served on the National Executive for 16 years in total, in two different stints. The first was from 1993-2001 (National Secretary 1995-97, Vice President 1997-2001). After a two-year break, he served as Vice President again from 2003-2011. For much of the 1990s he was also our Wellington branch representative.

The six life members to date are Drs John Hawke (deceased), James Judson, George Downward, Allen Fraser, Peter Roberts and Brian Craig.

Funding model for vocational medical training

For some months Health Workforce New Zealand, and in particular its Executive Chair Professor Des Gorman, have been promoting a change to the funding model for vocational medical training.

As part of this promotion, HWNZ held a national workshop in July in Auckland to discuss a paper prepared by Professor Des Gorman. The Executive Director attended the workshop. Other attendees

were mainly from DHBs (including chairs, chief executives, chief medical officers, chief operating officers and HR managers), Colleges, professional associations, Resident Doctors Association, New Zealand Medical Association, Ministry of Health and the Medical Council. Overall, however, there was a proportionate under-representation from the medical profession employed by DHBs.

At the workshop there was acceptance that the current system required change. However, there was an underlying but also understated difference between those who believed change should be radical and those (primarily Colleges and Medical Council) who believed change should be more incremental. The National Executive supports the more incremental approach but the difficulty is that the promotion of change is at a high conceptual level.

A second national workshop will be held in November. Given its importance, Dr Derek Sherwood, Chair of the Council of Medical Colleges, will give a presentation on this subject to Annual Conference.

First international conference of doctors' unions

This event was initiated and organised by Marburger Bund, the German doctors' union which has previously been represented at our Annual Conference. The conference was attended by the Executive Director on 13-14 June in Germany's largest university hospital, Charité Campus in Berlin Mitte. It was well organised with two well-chosen subjects that connected in different ways with attendees. In total, there were representatives from 24 countries. Arising out of the presentations and subsequent discussion, resolutions on each of the two subjects were adopted. There was good opportunity for informal networking.

Two resolutions were adopted on the main themes of the conference.

1. Migration of doctors

The participants of this first international conference of doctors' trade unions support the implementation of the 2010 WHO Code of Practice on the International Recruitment of Health Personnel. It is vital that source and destination countries benefit equally from migration and therefore it is particularly important that all countries strive to train enough doctors to meet their own internal needs.

Furthermore, it is a primary objective of doctors' trade unions to ensure that migrant doctors enjoy the same working conditions as domestically trained doctors and don't suffer any discrimination.

To support migrant doctors, the participants of the 1st International Conference of Doctors' Trade Unions agree:

- To provide information on working conditions, recognition of medical training and language requirements to doctors who want to migrate to or who are new to their chosen host country.
- To make their members, upon request and whenever possible, aware of doctors' trade unions abroad so as to help them to find union support in their chosen host country.
- To exchange, as far as possible, information on migration issues with other doctors' trade unions.

2. Working time

Patient safety and the health and safety of doctors should be the guiding principles of any working time regulations that cover doctors. Excessive working hours not only pose a threat to patients and the physical and mental health of doctors but make the medical profession less attractive and, as a result, aggravate the existing shortages of doctors in many countries.

The participating doctors' trade unions:

- Call upon the responsible authorities to enforce existing working time regulations.
- Are committed to fight against any attempts to reduce the health and safety provisions in existing working time regulations.
- Aim to reduce long working hours in accordance with their members' needs and preferences, especially, with regard to a better reconciliation of work and private life.

The Executive Director gave presentations on both themes. The second conference will be organised in Uruguay, provisionally in April next year.

Consensus statement on sugary drinks

The National Executive has previously resolved to take a wider view of the Association's role supporting initiatives to improve the health of New Zealanders. In July the New Zealand Dental Association wrote to the Association seeking support for a consensus statement on sugary drinks. The statement canvasses the research indicating that sugary drinks are a problem and sets out seven steps, including the introduction of a teaspoon of sugar icon on packaging, warning advertising, regulation of advertising to children, a social marketing campaign aimed at switching consumption to water, especially at schools and by local government. The statement stops short of advocating a sugar tax.

The Executive considered this request at its August meeting and agreed to endorse the consensus statement. It also agreed to the use of the Association's logo with the statement and agreed to Association representation at a meeting to discuss further steps to be convened by the Dental Association.

Dealing with bullying, harassment and other inappropriate behaviours

Following reporting of surveys on bullying, sexual harassment and other inappropriate behaviour of resident doctors and medical students, the Association (through Senior Industrial Officer Lloyd Woods) has been involved in national discussions about how best to address these issues.

In March, he and Industrial Officer Sarah Dalton attended an international bullying research conference in Auckland. Of particular note was that 'zero tolerance' and similar punitive systems actually increase bullying and the greatest determinant of the likelihood of being bullied is not what one does for a living, but where you work. It led to the assessment that the way to deal with bullying is through low level resolution with restorative outcomes. The best approach overall is to develop a workplace culture where the bullying does not occur in the first place.

In discussions on the national taskforce established last year, a fundamental disagreement emerged regarding anonymous complaints. The Association saw anonymous complaints as impossible to answer and seriously breaching natural justice. This has also been discussed in the National Bipartite Action Group.

Some DHBs are looking at better ways to deal with these problems themselves and some of these projects seem to be working to decrease bullying and deal better with the fallout where it does occur. However, there is a need for a system that can cover all employees in all DHBs rather than the patchy responses currently in use.

This led to consideration of work by the Cognitive Institute and, in particular, a new system that has been implemented to combat bullying at the Royal Melbourne Hospital which avoids anonymous complaints through a 'messenger' system. On the Association's initiative, a visit of representatives of various organisations including ASMS (Angela Belich and Lloyd Woods), Resident Doctors Association, DHBs, other health unions and NZ Medical Association was organised in Melbourne in August to meet the Cognitive Institute and visit the Royal Melbourne Hospital. The Association also took the opportunity to discuss this system with the Australian Medical Association (Victoria).

At its August meeting the National Executive agreed to support the national office continuing to investigate and research the Cognitive Institute's 'Promoting Professional Accountability' programme, with a view to agreeing a suitable version for use in DHBs.

Council of Medical Colleges

This year the Association has had two meetings with the Council of Medical Colleges. The first was in February where Derek Sherwood and Sue Ineson (CMC Chair and Executive Director respectively) met the Executive Director and Deputy Executive Director primarily to discuss the proposal to change the model for allocating funding for vocational medical education.

The second was the forum attended by Deputy Director Angela Belich and Principal Analyst Charlotte Chambers, which sought views and support for an international campaign entitled 'Choosing Wisely' aiming to reduce "unnecessary tests, treatments and procedures", to result in higher quality of care. The rationale behind the campaign is that many clinical interventions are unnecessary and cost money. These unnecessary interventions can result in "sub-optimal care for patients which at best adds little or no value and, at worst, may cause harm". The supposed value of a treatment requires better evaluation by a more thorough consideration of possible outcomes and the associated cost of the treatment. As such, the campaign seeks to challenge the view that in medicine, 'more is always better'.

The Council has approached the Association for support for its 'Choosing Wisely' campaign. A survey of ASMS members is running as a collaboration between the Council and the Association closing in late November.

Activity in the non-DHB sector

There are 226 ASMS members employed outside of DHBs. We have 16 collective agreements overall. Many of these are linked to the DHB MECA and we plan to renegotiate after the DHB MECA is settled. In each case the formal initiation process has been followed but actual talks put on hold. If the DHB MECA is further delayed, we may enter negotiations but 'reserve' the salary increases and other claims.

Delegated authority to the Executive Director under the Constitution for the ratification of non-DHB collective agreements was formally reiterated by the National Executive at their meeting on 3 April.

ACC

The ACC negotiations were very difficult but concluded with some success after six days of talks. Members received a salary increase, though these differed between different members. There are 32 members at ACC.

Family Planning

Last November we achieved a 5% pay increase, and improvements to CME allowances for our 23 members. However, the terms and conditions for these doctors still lag well behind those of other members. Improvements to salary and conditions, resulting from the new collective agreement included:

- Five percent pay increase
- Two new steps at the top of both the VR and doctors' scales
- Inclusion of BPAC to reimbursements schedule
- Additional long service leave at 25, 30 and 35 years
- Paid jury service leave introduced
- Increased CME leave (from five to ten days per annum) and expenses (from $1000 to $3000 per annum).

Iwi authorities

We have successfully negotiated a collective at Ngati Porou Hauora (two members) after a protracted period with an expiry of 30 June 2017. Negotiations with Ngati Toa Rangatira (18 ASMS members) are scheduled for November.

Ashburn House

A collective has now been successfully ratified and settled for the three members employed at Ashburn House.

Golden Bay Health

A new collective agreement has been successfully ratified and settled for the six members employed by this Primary Health Organisation.

Otara Union Health

We continue to experience significant difficulties gaining traction with the employers at this primary health care centre. The collective agreement expired more than a year ago and they refuse even to roll it over, citing financial difficulties. We find this attitude from a union employer particularly disappointing and will continue to engage into the new year. We have three members at this site.

Hokianga Health Enterprise Trust

We have a new collective agreement ratified and settled, along with an increase in members (now six). The inclusion of new after hours funding arrangements in the collective resulted in an 11%+ pay increase for these doctors.

Industrial team activities

The industrial team now has seven staff. It is led by Deputy Executive Director Angela Belich and consists of Senior Industrial Officers Henry Stubbs and Lloyd Woods, and Industrial Officers Steve Hurring, Sarah Dalton, Ian Weir-Smith and Dianne Vogel.

Job offers

During the year the industrial team advised 78 new appointees on their job offers.

Health and safety

Bullying allegations at various DHBs

We have recently dealt with a number of bullying allegations at different DHBs where the approach has been to 'use a sledgehammer to crack a nut'. Allegations have resulted in some SMO resignations due to a loss of faith in the DHB's processes. The Association has been very active in this area of work and we are actively looking for better ways of dealing with the problem (see above) and generally are looking for low level restorative solutions as the best way forward.

Independent investigation of bullying at Auckland DHB

An allegation of bullying that should have been dealt with promptly and informally within the department was grossly mishandled by ADHB, whose poor judgement and over-reaction was aggravated by a serious and distressing breach of confidentiality which only prolonged the proper resolution of the complaint, which eventually was shown to lack substance. It took an independent external investigation to find there was no bullying and that the DHB's policies and handling of the matter were flawed and unhelpful. ADHB has subsequently apologised to the parties involved.

Addiction as a health issue

In the past year we have dealt with several cases of addiction, including multiple relapses. Such cases are difficult and take time to resolve. Fortunately, DHBs seem to accept that addiction is an illness and, at least initially, should be treated as a health issue. Our experience and the medical literature clearly shows that once a doctor acknowledges their addiction, with appropriate treatment and support (including most importantly their continued employment) there is a very high success/recovery rate.

Over the years we have gained valuable experience working closely with the Medical Council, employers, treatment facilities and support groups and are now well placed to advise and assist members who find themselves trapped in an addiction.

Health and safety policies

The Health and Safety at Work Act has led to most DHBs reviewing their bullying and harassment policies. The Association has also been consulted on a number of wellbeing policies.

Job sizing

For many years the ASMS model and methodology of job sizing has provided a reliable and objective measure of SMO full-time equivalents required to meet the needs of a service. ASMS assistance in guiding and sometimes leading job sizing reviews continues to be a big part of the industrial team's workload. Such exercises are easy to start but slow to conclude, particularly when it has become clear that more SMOs are required than a DHB is willing to fund. We are currently facing a number of impasses in services where DHBs are reluctant to address this unmet need in SMO staffing levels.

As a result of the Association's work on fatigue and burnout, the industrial team is looking at job sizing exercises which have identified a clear shortfall in FTE, where the DHB will not agree to

appoint additional FTE, and approaching them as a breach of a DHB's duty to provide a safe workplace.

Southern DHB has adopted a general response to identified shortfalls in staffing through job sizing of "we have no money; you will just have to cut the service". The Association has made clear that if that is the DHB's answer, the management representatives will have to front up to the public on the cuts and the SMOs would just implement them. Four areas have been told to cut services in this way.

Leave

CME leave – 10 days leave "each calendar year"

Locums/private practice during annual leave

Niggling approaches to CME

Sabbatical rationing at ADHB

Redundancies and Reviews

1. Hawke's Bay Ophthalmology
2. Auckland Regional Sexual Health Services
3. Auckland and Waitemata DHBs palliative care services
4. Risks for IMGs arising from fixed term contracts
5. Waikato DHB O&G Department
6. Radiology at Nelson Marlborough DHB
7. Reviews increasingly resulting in actual/potential redundancies

Despite unmet need, there has been a noticeable increase in the possibility of redundancies arising out of departmental reviews (not reviews arising from transfers of business to other entities).

Official Information Act requests for surgical complication data – Ombudsman's ruling

On 30 June (his last day in office) Ombudsman Ron Paterson issued a decision in response to complaints by journalists against multiple DHB refusals to disclose surgical complications data at the individual clinician level. He did not uphold the journalists' complaints. Instead, consistent with the views expressed by key health agencies, including the Health Quality & Safety Commission, that the practice of public medicine is essentially a team-based activity, he has advocated for public access to team or unit level complication data (once this data is robust enough for release). Despite this opinion, the Ombudsman has nevertheless required DHBs to release volume statistics by procedural type for individual SMOs, contrary to the advice provided by the Association. He has also signalled that the issue of public access to individualised complications data is not a settled matter, though whether future Ombudsmen adopt the same approach is unknown. Both complication rates and volume data could lead to the creation of individual 'league tables'.

Speaking out case

In the course of the year we were called upon (with MPS) to support a senior medical officer whose public utterances on several matters of public concern had caused intense embarrassment and irritation to several large public and private undertakings. The Association will jealously protect and defend our members' rights to engage in legitimate public debate and dialogue in matters related to their particular specialty, areas of expertise and the wider public interest. This particular case has yet to be resolved but resulted in a substantial independent inquiry under clause 42 of the MECA, which essentially found in favour of the doctor concerned.

Waitemata ED shift work

A draft shift agreement is currently under discussion by members in the department. The draft includes a night rate for SMOs, recovery time, and a research and monitoring provision.

Complaints and disciplinary issue

The past year has seen 10 cases of members whose employment has come to an end 'involuntarily', other than for reasons of redundancy, through 'negotiated' retirement or exit packages, for a variety of reasons including age or health-related concerns and behavioural or clinical practice concerns. It is unusual for senior doctors to be 'dismissed', but it does happen. Some of those who have gone might still be employed had they shown a little more insight and contrition earlier in the process that led to their departure.

Clinical investigations under MECA clause 42

Typically, the industrial team is involved in 10 or 12 investigations under clause 42 each year, and such was the case this year. Invariably we work very closely with MPS to support the member concerned. These are time consuming and difficult cases and very stressful for the member concerned. Almost all of them will involve some form of restriction on the SMO's practice while the review is undertaken. They are seldom completed in less than 12 months and not infrequently will end up with the Medical Council. Collegiality, early insight and a willingness to listen to the concerns of colleagues (whether senior, junior, nurses or other health professionals) is the best protection SMOs/SDOs have against what are invariably distressing and sometimes devastating processes.

National payroll issues

The Ministry of Business, Innovation and Technology revealed this year that a number of payroll programmes have systematically failed to pay employees correctly for their holidays. The group most likely to be affected are casual employees, those working shifts (specifically where these attract different rates of pay and those on commission. It is possible that the issues are wider than this and include other instances where pay varies during the year.

The CTU engaged with the Labour Inspectorate, which has resourcing issues as it has only three payroll specialists nationwide. These specialists are manually calculating entitlements and then checking against payroll calculations. The CTU proposed a joint approach with unions and employers approaching the payroll companies.

DHBs are included in those employers affected by this issue, which may go back to 2004. It is important to remember that there is a six-year statutory limitation on payment of salary arrears. Eight DHBs (this apparently includes the three Auckland DHBs, Northland, Southern and Nelson Marlborough) have their payrolls done by AMS, the company that provided the software that has miscalculated the police and MBIE payrolls. A further eight DHBs use a payroll provider called Northgate Enterprises and the final four each have an individual provider.

This issue was raised at JCCs. All DHBs indicated that they were investigating the issue and did not expect that they would discover a problem.

Mediations and matters before the Employment Relations Authority/Employment Court

- The Association is challenging a DHB that is denying a pregnant SMO her right to paid sick leave, when on medical advice to protect the unborn foetus she gave up work two months before the expected date of birth.
- Retiring Gratuities.
- Following a second mediation and several informal meetings between the industrial officer concerned and senior management, we settled a long running job size back pay claim involving a number of SMOs. Their claim was for a substantial sum of money and the case had been set down for a two-week Employment Court hearing. The Association had spent over $60,000 in legal fees by the time of settlement and might well have spent at least twice as much again if the case had gone to trial. The case had got to the point where a hearing had been scheduled with the Employment Relations Authority. A confidential settlement was reached.
- NMDHB taking ASMS to mediation.

Research team activities

The research team has two staff: Director of Policy & Research Lyndon Keene, and Principal Analyst Dr Charlotte Chambers.

This year, two major studies led by Principal Analyst Dr Charlotte Chambers have involved national surveys of ASMS members and associated work. The first study, assessing the extent of fatigue and burnout in the Senior Medical Officer (SMO) workforce, published as a *Health Dialogue* in August 2016, found 50% of respondents reporting symptoms of burnout. The second study is to gain a better understanding of the effects of an ageing workforce on future workforce capacity as well as providing key insights to the reasons why people are considering exiting the public health workforce. Preliminary results from this work will be presented to the 2016 Annual Conference and will be published in full early in the New Year.

These two studies will add to the senior doctor workforce intelligence being gathered by ASMS following on from last year's study on the prevalence of 'presenteeism' in the SMO workforce, which has been accepted for publication in the *New Zealand Medical Journal*. The aim is to continue to develop a valuable source of information for promoting evidenced-based workforce policy.

To complement this work, surveys of clinical leaders are being undertaken in selected district health boards (DHBs) to ascertain current SMO staffing levels and required SMO staffing needs as assessed by respondents, taking into account the SMO staffing capacity needed for patient centred care, clinical leadership, appropriate leave-taking and unmet need. The first survey (Hawke's Bay DHB), was published in July 2016; the second survey (MidCentral DHB) was published in November 2016. Both indicated substantial staffing shortfall. Further surveys are underway.

Four papers have been produced promoting 'patient centred care', explaining what the approach involves from a medical specialist perspective, why it is so important, identifying the barriers to its implementation, and discussing ways to make progress. Further work on patient centred care is planned for the new year.

A Research Brief was published in June 2016 summarising the literature about shift work, with a particular focus on issues arising from doctors working at night in hospital emergency departments.

Policy & Research Director Lyndon Keene co-wrote pre- and post-Budget analyses of 2016 Vote Health funding with Council of Trade Unions economist Bill Rosenberg. Both are co-authors (also

ASMS Executive Director Ian Powell) of an editorial on health funding published in the *New Zealand Medical Journal* in May 2016.

An analysis of New Zealand specialist workforce demographic trends has been completed and is awaiting publication.

An analysis of international medical graduate (IMG) trends relating to the specialist workforce is underway.

A number of submissions have been presented to government agencies, including to:

- The Foreign Affairs, Defence and Trade Select Committee on the Trans Pacific Partnership Agreement (TPPA)
- The Ministry of Health on the Updated New Zealand Health Strategy
- The Ministry of Health on the Mental Health Workforce Plan
- Health Workforce New Zealand on the Voluntary Bonding Scheme for 2017
- The Ministry of Health on the on Health of Older People Strategy

Research team activities include presentations and attendances at conferences related to specialist workforce issues, and Dr Chambers has attended numerous Joint Consultation Committees in support of the industrial team.

Health Sector Relationship Agreement Steering Group

The Association has attended four of the five meetings of the tripartite Health Sector Relationship Agreement (HSRA) Steering Group this year. The participants are the Ministry of Health (through the National Health Board), all 20 DHBs, and each of the CTU-affiliated four main health unions (NZ Nurses Organisation, Public Service Association, E tū Union, and the Association). All are signatories to the HSRA. This body is the primary means by which the Government, through the Ministry of Health, DHBs and health unions, engages on a national level.

Participation in the steering group continues to be a valuable opportunity for the Association; a regular feature is the opportunity to raise issues at the start of each meeting.

The main issues and agenda items in the meetings have been:

- the development of 'high performance-high engagement' workplaces
- discussion on the New Zealand Health Strategy
- amendments to the Employment Relations Act
- ensuring that contracting out proposals are considered in the context of the HSRA
- workplace bullying and bystanders
- payroll compliance with the Holidays Act
- funding of 'Very Low Cost Access Practices' (primary care).

National Joint Consultation Committee (NJCC)

The National Joint Consultation Committee is set up under the national ASMS-DHB MECA for the purposes of constructive engagement and decision-making between the Association and the DHBs collectively. Four meetings have been held this year.

Topics of discussion have included the results of our burnout survey; compliance with the Holidays Act; Health Partnerships Ltd (including a session with HPL's chief executive); the proposed new funding model for vocational medical training; the Association's 'patient centred care' papers; the revised New Zealand Health Strategy; bullying and other inappropriate behaviour; ACC focus on treatment injuries (session with the ACC Chief Medical Officer); and senior medical officers working as locums or in private practice while on annual leave.

Joint Consultation Committees (JCCs)

In their 11th year of operation, JCCs are a vital part of the Association's work. Three JCCs have been, or will be, held in each DHB this year. Overall, attendances have been good although on at least one occasion, in four different DHBs, it was poor.

The following have been raised in all or nearly all JCCs:

- the Association's published results of the presenteeism survey that was reported to the 2015 Annual Conference
- the Association's approach to minimum safety standards in services and departments
- the Association's formal clinical leadership paper
- the application of the appointments clause in the MECA to senior medical staff involvement in appointing suitable persons responsible for the provision and management of clinical services
- impact of increasing acute admissions on systems in the context of the national health targets
- compliance with Holidays Act requirements
- *NZ Medical Journal* article on health funding
- senior medical staff involvement in strategic planning, including procurement and contracting out
- results of the Association's hours of work and burnout survey
- monitoring of the MECA requirement for suitable overnight accommodation at the workplace
- application of the MECA appointments clause to clinical leadership positions
- reviewing relocation expenses policy in respect of the MECA requirement
- information technology frustrations in several DHBs
- in some JCCs, either the planning for or evaluation of joint senior medical staff engagement workshops.

In addition to the above, some issues specific to individual JCCs were:

Northland

Mental health review; masterplan for the public hospital sites; use of rural hospital doctors at Dargaville Hospital; exit interviews for resigning clinical leaders; effectiveness of the DHB's clinical leadership training programme; returning radiology to an in-house service; running of capital expenditure committee; slowness in installation of healthy food vending machines; and change from chartered to commercial flights to Kaitaia.

Waitemata

Review of emergency departments; lack of leave cover arrangements in mental health; palliative care growth and capacity; clinical leaders stifling senior medical officers' concerns; new Institute for Improvement & Innovation; and capacity for primary care to cope with chronic mental health conditions.

Auckland

Expired ID cards and access to lifts; introduction of clinical leadership positions; car parking pressures; clinical concerns in pathology service; need for greater clarity in CME application process; and hospital shuttles between Greenlane and Auckland City Hospitals.

Counties Manukau

Regular provision of CME balances; car parking; recruitment at time of scarcity; problems with BadgerNet in maternity service; problems with auto-testing, particularly in emergency department; new interpreter service; and the Compass debacle.

Waikato

Management initiated 'medical efficiency review' involving job sizing (contentious); CME leave balances dispute; SMOs working when on annual leave; and development of CME guidelines.

Bay of Plenty

Effects of high patient admissions and nurse shortages; improving workplace culture; and violence against clinical staff.

Lakes

Cyber security concerns; performance of a locum agency; December closure of theatres concerns; and provision of financial data to departments.

Tairawhiti

Annual leave liability; performance appraisal system; and promotion and awareness of secondments.

Taranaki

Review of functioning of clinical leadership positions.

Hawke's Bay

Concerns over management's approach to job sizing and clinical service planning.

Whanganui

Sub-regional collaboration with MidCentral DHB; and review of senior and resident medical officer administration.

MidCentral

Audit of women's health service; restructuring of senior management team; diabetes service; pressures in general medicine; and slow progress in job sizing.

Wairarapa

Pressures on orthopaedic service; RMO weekend cover; emergency department staffing; organisational restructuring following changes in sub-regional relationship; and management of rosters when falling to less than one-in-three.

Hutt Valley

Pressures on mental health service; on-call phone provision; crisis resolution service; emergency department staffing; and tighter financial controls over CME expenses claims.

Capital & Coast

Crisis resolution service and CME guidelines.

Nelson Marlborough

Coping with funding shortfall; problems with HR kiosk; privatisation threat to radiology service; and strengthening of clinical administration.

West Coast

Redevelopment of Grey Hospital and the Buller site; Trans Alpine collaboration; senior medical officer life insurance (earthquake damage); new orientation programme for international medical graduates; and changes to local availability allowance.

Canterbury

Appointment process for vacant chief medical officer position; workload and staffing pressures in mental health; level of non-clinical space in rebuild; job sizing delay in general surgery; ongoing impact of earthquake on health funding; and noise levels in ICU.

South Canterbury

Coping with the deficit; senior management restructuring; shift patterns and staffing in emergency department; effects of reduced Air New Zealand flights; and receipt processes for the annual practising certificate.

Southern

Redevelopment of Dunedin Hospital with particular reference to ICU; excessive acute workload at Southland Hospital; retrieval service for Queenstown; re-negotiation of clinical leaders' employment agreements; pressures on the radiology service; university academic posts funding; and specialist shortages in haematology, intensive care and anaesthesia.

Joint Association-DHB engagement workshops

For eight years the Association and individual DHBs have been holding joint senior medical officer engagement workshops. Almost always they are a half-day and involve rescheduling of elective activity. This year there have been successful workshops at Waitemata (2), Counties Manukau and Canterbury.

National branch officers' workshop

National branch officer (presidents and vice presidents) workshops have been held since 2011, two in each of 2012 and 2013, and one in every subsequent year.

This year the workshop was held on 12 August. The programme included:

- update on the national DHB MECA negotiations – Executive Director Ian Powell
- results of the burnout survey (which was immediately followed by the public release) – Principal Analyst Charlotte Chambers
- JCCs and building branch engagement – Ian Powell and Senior Industrial Officer Lloyd Woods
- a session on 'hot' local topics.

National Bipartite Action Group

The Association is now a full member of the National Bipartite Action Group (National BAG).

The National BAG was established in 2010 as part of the settlement between the 20 DHBs and three health unions (Public Service Association, Nurses Organisation and Service and Food Workers Union). Subsequently the Resident Doctors' Association, APEX and the Medical Laboratory Workers Union joined.

At its meeting in November 2015, the National Executive decided to take up the offer made by the National Bipartite Action Group for the Association to become a full member.

A minor change was made to the terms of reference to clarify that, though affiliated to the CTU, the Association was never part of the National Bipartite Framework and therefore not required to attend the local Bipartite action group meetings at DHBs.

The National BAG meets every two months face-to-face and by teleconference in the intervening month. Lloyd Woods attended four meetings and Angela Belich attended two.

This year the National BAG has once again been useful in injecting sense into the wearing of masks debate. It has proved very useful in moving toward a low level approach to allegations of bullying and has made progress on guidelines for protecting DHB staff from violence.

Staffing and base salaries

We have been recording the salaries of specialists and medical and dental officers working at DHBs throughout the country since 1993. We request the number of senior medical and dental staff on each step of the salary scale as at 1 July 2016, whether they are ASMS members or not. The most recent survey recorded data as at 1 July 2016 and found:

- A total of 4560 specialists and 484 medical and dental officers employed resulting in a total senior medical workforce of 5044 individuals (a 5.1% increase in specialists and a 2.8% decrease in medical and dental officers compared with the previous year).
- 2946 (64.6%) of specialists were male and 1614 (35.4%) were female (a growth in the number of male specialists of 5.2% and a growth in the number of female specialists of 5%).
- 256 (52.9%) of medical and dental officers were male and 228 (47.1%) were female (a decrease in the number of male medical and dental officers of 1.5% and a decrease in the number of females of 4.4%).
- An increase in the average specialist salary of 5.7% and a decrease in the average medical and dental officer salary of 2.8% to $203,930 and $136,292 respectively.

- The highest average salary for specialists is this year at Whanganui DHB ($203,164) and the lowest is at Counties Manukau DHB ($190,462).
- The highest average salary for medical and dental officers is shared between Tairawhiti, South Canterbury and Southern DHBs ($166,000) with the lowest average salary to be found at Auckland DHB ($137,350).
- This year there were no medical or dental officers recorded at Wairarapa DHB representing a decrease of 6 individuals from 2015.
- 1802 (40%) were on the top step of the specialist salary scale and 232 (48%) were on the top step of the medical and dental officer salary scale.

Health Sector Directions Forum

This is an annual briefing following the budget. This year it included an update from the Ministry of Health on the New Zealand Health Strategy. The strategy was explained as supportive of loosening up how providers deliver services and what services are provided, so long as outcomes are met and there is a clear accounting of costs, etc.

Budget presentations were given by Treasury, Bill Rosenberg from the CTU and Mhairi McHugh from the Ministry of Health. The Ministry reported that the review of the population-based funding formula decided that the structure of the PBFF with current demographic weighting is sound. Both the Treasury and Ministry presenters didn't stay to engage on the issues, so the meeting was less valuable than it could have been.

Medical Workforce Taskforce Governance Group

In 2013 Health Workforce New Zealand (HWNZ) established a Medical Workforce Taskforce Governance Group in response to the challenges over the placement of increased numbers of post-graduate medical students into PGY1 positions. Its brief has since widened to include the whole medical workforce career, and its membership expanded.

The Group was convened by HWNZ Chair Professor Des Gorman. Recently Dr Ken Clark (MidCentral Chief Medical Officer and Chair of the CMOs national group) has assumed the Chair. The Group includes representatives of DHBs (Chief Executives and Chief Medical Officers), medical schools, Ministry of Health, Medical Council, Council of Medical Colleges, ASMS (represented by the Executive Director), Resident Doctors' Association, New Zealand Medical Association (including its Doctors-in-Training Council), and New Zealand Medical Students Association. Its meetings are normally 90-minute teleconferences but there have also been two constructive 'face-to-face' meetings in February and October.

Features of the meetings have been:

- compilation of data on the profile of the senior and resident medical officer workforce
- funding of post-graduate medical training (discussed separately above)
- specialist workforce capacity
- community-based attachments (house surgeons)
- DHB senior medical officers undertaking locum work while on annual leave (it was agreed to take this no further).

APAC Forum

Deputy Director Angela Belich, Director of Policy & Research Lyndon Keene and Principal Analyst Charlotte Chambers attended the 5th APAC forum in Sydney, Australia, from 12-15 September.

The theme for this year's forum was 'exploring new frontiers'. Accordingly, there was a strong emphasis on motivation, transformational change and opportunity through collaboration. The ASMS team were left feeling agnostic about recurring themes focusing on motivation - which we do not believe is lacking in the health sector - and noted the absence of discussion on broader structural factors (such as funding and international health workforce issues) that were left unquestioned.

Plenary sessions were diverse. Particularly noteworthy were sessions on bullying and the insistence that all organisations pay attention to small acts of incivility before they grow into 'gnarly old oak trees of bullying and misery' and a session on health equity, run by members of New Zealand's Health Quality & Safety Commission, with statistics showing not only that Maori life expectancy rates are continuing well below those for non-Maori but also that Quintile 1 Maori life expectancy rates were below those of Quintile 5 non-Maori rates.

Updated New Zealand Health Strategy

Among the submissions produced by ASMS this year (see 'Research team activities' for the full list) the most detailed was that to the Ministry of Health on the draft Updated New Zealand Health Strategy. The main points covered in the submission include:

- Allowing little more than a month for consultation on the draft strategy was insufficient time to enable a proper analysis of what was being proposed.
- The ASMS supported the proposal to retain the seven principles of the original New Zealand Health Strategy. There was also much that we did not support and had concerns about.
- The document used selective data to describe current health issues and challenges. It did not acknowledge the efficiency and quality of our health system relative to comparable countries, or the extent of New Zealand's current health need, or significant health inequality.
- The challenges relating to future health spending were overstated and were being used as the rationale for introducing 'significant change' to the current health system model. Evidence shows the main weakness of New Zealand's health system is not the model but *access to it*.
- There is a significant opportunity to improve the cost-efficiency and effectiveness of our health services by giving a stronger commitment to distributive clinical leadership, which the document had ignored, and implementing a genuine patient centred care approach.
- The document acknowledged challenges such as the ageing health workforce and New Zealand's high dependency on overseas recruitment, but offered no responses of any substance.
- The draft strategy's aim to have a 'smart system' depends largely on capital investments, but there is evidence of an accumulating DHB 'capital deficit'.
- The document focused on 'living well, staying well, and getting well'. We suggested 'Start well, live well and end well (or go well)' would reflect a better range of priorities.

Council of Trade Unions

The Association first affiliated to the Council of Trade Unions (CTU) in 1990. As in previous years the Association continues to benefit from this affiliation at both a national office level and with the affiliates. CTU work analysing health spending and Vote Health in the Budget continues to be very valuable (Director of Policy & Research Lyndon Keene provides critical assistance for this work).

The CTU has been re-examining its employment law policy in the hopes that political parties may take up these changes in their election policies. The examination has two arms: the first is to strengthen the current legislation, reversing the changes made by the current government that have weakened collective bargaining. Though these changes have not had an immediate effect on our national DHB MECA, the negotiations have taken place in a context where the duty to conclude may allow employers to fail to conclude collective bargaining. It would seek to strengthen the current law by firstly reinstating the changes that the current government has made to the Employment Relations Act, such as the removal of the requirement for new employees to be started on the relevant collective agreement for their first 30 days, the removal of the duty to conclude collective bargaining, and restoring the unions' initiation advantage.

The second arm for the proposal is to institute 'industry standard agreements'. These would be minimum agreements either negotiated between unions and industry groups or, if that fails, have such a minimum set by the Employment Relations Authority. These standards would reflect the minimum in the industry or occupation. The intention would be to set a floor, including a floor for health and safety in areas where there is currently no collective agreement. This should not be confused with the use of the term 'industry standard' by the DHBs' negotiating team in in our current MECA negotiations.

At its September meeting the National Executive voted to support the CTU policy.

The Executive Director usually attends the CTU's quarterly National Affiliate Council. Issues considered by the Council included:

- continuation of the new strategic direction for the CTU, doing fewer activities better, especially where resources are involved, and with a particular focus on union membership growth
- CTU employment law policy (discussed above)
- the Employment Standards Legislation Bill.

Meetings with Director-General of Health

The Executive Director has regularly scheduled meetings with the Director-General of Health, Chai Chuah. These meetings are very useful to the Association. They are an opportunity to raise issues, perspectives and differences that otherwise might not be brought to the Director-General's attention.

Topics included:

- review of the New Zealand Health Strategy
- Ministry of Health restructuring
- national DHB MECA negotiations
- conduct of DHBs in pay rates to senior medical staff undertaking additional duties as result of the resident medical officers' strike
- results of DHB-employed senior doctors' hours of work and burnout survey

- difficulties in specific DHBs including Whanganui, Hutt Valley, Capital & Coast, Whanganui and Southern
- Canterbury senior medical officer complaint against senior Ministry of Health official.

International travel

The following international travel was undertaken by national office staff since the previous Annual Conference:

- The Executive Director attended the two Industrial Coordination Meetings organised by the Australian Medical Association, in conjunction with the Australian Salaried Medical Officers Federation, in Canberra in April and in Brisbane in September. Issues discussed included reviewing the AMA's national code of practice for hours of work, shift work and rostering for hospital doctors; international medical graduates in the medical workforce; Royal Commission on trade union governance and corruption; review of medical internships; AMA position paper on personal safety and privacy for doctors; medical workforce data; budget cuts and new health legislation in Western Australia; strategic developments and initiatives within ASMOF New South Wales; review of AMA position statement on workplace facilities and accommodation for hospital doctors; National Medical Training Advisory Network workforce reports; role of the AMA in trainee disputes with Colleges; public hospital privatisation in New South Wales; New South Wales inquiry into violence against emergency personnel; preparation for collective bargaining in Victoria; and collective bargaining in Western Australia. The Executive Director gave presentations on our approach to the national MECA negotiations and job sizing in the Canberra and Brisbane meetings respectively.
- The Executive Director, Deputy Executive Director, Director of Policy & Research (Sydney based) and Principal Analyst attended the International Medical Symposium in Sydney in March. The focus for the event was 'future challenges for the medical profession' following on from a symposium on the same theme last year. It was an excellent mix of political and professional matters and served the policy team well in terms of justifying and stimulating research and policy initiatives. Prior to the conference, the Executive Director met Federal and New South Wales executive directors of the Australian Salaried Medical Officers Federation.
- The Executive Director visited Germany and England in June. The prime purpose was to attend the First International Conference of Doctors Unions in Berlin. While in Berlin he met with Marburger Bund where subjects included the effect of changes to employment law on collective bargaining rights and the union's strategy to legally challenge it and overseas doctors in Germany. In England he had meetings with the Chair of the British Medical Association, with Professor Martin McKee, the Hospital Consultants & Specialists Association, Trade Union Congress, the Unite union (the largest in UK) whose members include doctors, a health economist, and the Medical Protection Society. Primarily it was an opportunity to update on developments in the National Health Service and also the resident doctors industrial action.
- Deputy Executive Director Angela Belich and Senior Industrial Officer Lloyd Woods visit to Melbourne over bullying and harassment in August (discussed above).
- The Deputy Executive Director, Director of Policy & Research and Principal Analyst Policy & Research attendance at the APAC forum in Sydney in September (discussed above).
- Executive Officer's sabbatical in Europe, July-October (discussed above).

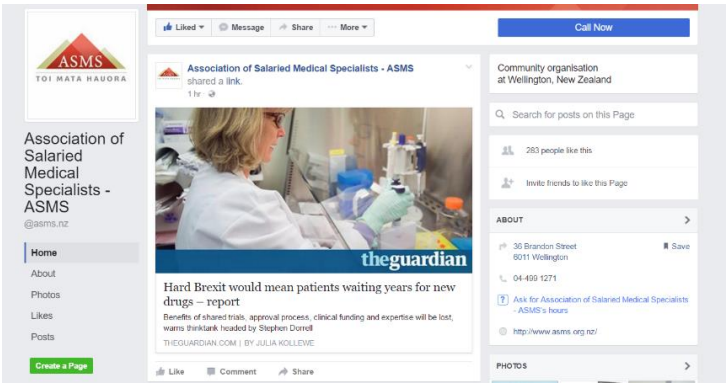
Association communications

The Association has carried out a wide range of communications in the past year with members, the public, and relevant agencies such as the Ministry of Health, Health Workforce New Zealand, professional colleges and bodies, and other health unions.

We have used the following communication channels:

- ***Website*** – the ASMS website (www.asms.nz) is updated daily to ensure it remains responsive and topical. Content on the website continues to expand, with more videos being added to the site along with 'tabs' on the home page to provide additional information about the ASMS-DHB MECA negotiations and our patient centred care discussion papers.
- ***Media*** – production of media releases and responding to requests for interviews; supporting ASMS members to be clinical spokespeople on issues within their expertise; providing copies of key ASMS publications to media organisations to generate interest in coverage; keeping ASMS National Executive informed of significant media trends; daily media monitoring. The ASMS Executive Director provides a regular column for *NZ Doctor* magazine.
    - *In more detail*: our media releases have covered a range of topics, including minimum staffing levels in public hospitals; workforce shortages (overall and also focusing on particular specialities such as forensic pathology); research into unmet health need; presenteeism and burnout; ongoing resourcing pressures for Canterbury DHB; likely impact of the Trans Pacific Partnership Agreement (TPPA); leadership issues within the health sector; the inadequacy of public health funding.
- ***Publications*** – production of the ASMS quarterly magazine, *The Specialist*; Health Dialogues (eg, on presenteeism and burnout), Research Briefs (eg, on shift work and SMO staffing levels), advice documents on topical issues, a new series of patient centred care papers, Q&As, submissions, and regular electronic newsletters to members about both national and regional issues. Each issue of *The Specialist* includes articles about members and workforce issues as well as analysis, commentary, and topical cartoons by Chris Slane (2015 Cartoonist of the Year).

Social media – ASMS has an active presence on various social media channels, with a particular emphasis on Facebook, Twitter and YouTube. Most items posted on the website are also placed on social media to broaden coverage, and we have a small, loyal following that increases significantly when particularly topical issues are posted. The ASMS YouTube channel houses all of our videos – they can be viewed there or via the links placed on our website.



- ***Events –*** communications advice and support has been provided for several events in the past year, including the ASMS Annual Conference, the annual branch officers' workshop, and the joint ASMS-NZMSA conference on the future medical workforce.
- ***Videos*** – ASMS has produced further videos in the past year, and these are available on the ASMS website or our YouTube channel. In addition to videos of the keynote speakers at ASMS conferences, we have also made a series of five videos about health funding featuring ASMS Director of Policy & Research Lyndon Keene, and two videos about presenteeism and burnout by ASMS Principal Analyst Dr Charlotte Chambers. These provide short, easily digested snapshots of the issues, with links to more substantive articles and reports to provide greater depth.
- ***Joint projects*** – ASMS has also provided communications support for a range of events involving organisations we have either partnered with or sponsored. In addition to the joint workforce conference with the New Zealand Medical Students Association, we have promoted the research into levels of unmet health need being led by Christchurch surgeon Phil Bagshaw, public panel discussions on 'speaking out' organised by the education union NZEI, a Council of Trade Unions initiative to look at possibilities for digital campaigning, and the Medicine Stories Project being led jointly by ASMS members and Ko Awatea.

  - *In more detail*: Early in 2015 the National Executive agreed to provide seed funding for an innovative initiative that promoted doctors to write creatively about their experiences of practising medicine – stories, poems, insights and reflections. This initiative, now known as the Medicine Stories Project, has been driven by ASMS National Secretary Jeff Brown, former ASMS President David Galler and acclaimed GP and poet Glenn Colquhoun, with support from both the ASMS and Ko Awatea. It now has a website and is actively collecting and curating submissions from doctors (www.themedicinestoriesproject.co.nz).
- ***Organisational*** – work has continued in the past year to update and improve the 'look and feel' and overall professionalism of ASMS templates, publications and other materials. This work enhances the organisation's ability to communicate effectively.

Membership

The Association has had another record membership year (the 17th in succession). Membership as of 31 March 2016 was 4,351 compared with 4,271 at 31 March 2015, representing an overall increase of 80 (1.9%). We had 1,440 members in our first year of existence (1989-90).

The bargaining fee, introduced in 2008, attracted payments from 184 senior medical and dental DHB staff this year; to date 259 bargaining fee payers have converted to full financial members.

The following table shows annual membership increases since 1998-99 (the last year where we had a membership decrease):

Financial year	Total members	Increase	% Increase
1999-2000	1,856	105	6.0%
2000-01	1,974	118	6.4%
2001-02	2,072	98	5%
2002-03	2,218	146	7.0%
2003-04	2,335	117	5.0%
2004-05	2,574	239	10.0%
2005-06	2,738	164	6.4%
2006-07	2,833	95	3.5%
2007-08	2,995	162	5.7%
2008-09	3,481	486	16.0%
2009-10	3,496	15	0.4%
2010-11	3,572	76	2.2%
2011-12	3,878	306	8.6%
2012-13	3,901	23	0.6%
2013-14	4,167	266	6.8%
2014-15	4,271	104	2.5%
2015-16	4,351	80	1.9%

The average annual increase since our formation is 112 (7.8%). Under the period of the Employment Contracts Act (1991-92 to 2000-01) the average annual increase was 61 (4.3%). Under the period of the Employment Relations Act, since 2000-01, the annual average increase has been 163 (7.9%).

Currently membership is 4,356, an increase of 47 on the same period last year (this figure includes 19 late-renewals). Although membership growth in the latter part of the year is generally offset by factors such as retirements, we expect the 31 March 2017 membership to exceed current numbers.

Close to 90% of our members pay their subscription fortnightly by automatic salary deduction (about 75% of new members employed during the past year opted to do so).

About 10% of Association members are also members of the NZMA. 13% of members who joined the Association in 2016 were also members of the NZMA, compared with 22% in 1996.

Medical Assurance Society

The Association's collaborative 'preferred provider' relationship with MAS continues to strengthen. This includes the Society's substantial sponsorship of *The Specialist*. The Society has generously agreed to continue to sponsor the pre-Conference function this year (this sponsorship has been provided for several years).

Quarterly advisory consultancy meetings between the Executive Director, Executive Officer and Society Chief Executive Martin Stokes (and Sales and Marketing Manager Mike Davy) continue, with three meetings to date. MAS has also generously increased the funding for this consultancy.

Discussions at these quarterly meetings have included our national DHB MECA negotiations; the results of our burnout survey; and the further expansion to our industrial team.

Association finances

Two additional full time appointments (Policy and Research, Industrial) and relief administration assistance combined with the increased production of new publications and surveys, website improvements, increased industrial team activities resulted in a net operating deficit of $412,612. The 2016 budget had projected a surplus of $43,600.

The full year 2016 deficit was reforecast halfway through the year when considering the level of new staff required to meet members' needs and changes in their working environments – the final 2016 deficit was a considered and planned decision that fell after the setting of the 2016 budget and the end of that financial year. The decision was discussed at last year's Annual Conference.

The 2016 result had depleted our cash reserves to $2,912,839, (from $3,440,607 in 2015). The reserves policy target (set in 2013) is $3,200,000.

Administration

The administration team led by Yvonne Desmond (Executive Officer) has six permanent staff members, including Lauren Keegan (Assistant Executive Officer), Sharlene Lawrence (Office manager), Kathy Eaden (Membership Support Officer), Maria Cordalis (Administration Officer, Membership) and Lydia Schumacher (Administration Officer, Communications).

Information technology (IT) continues to be an important focus in support of the various teams and roles in the National Office and the increased complexity of work being undertaken. With a view to ensuring the organisation continues to have the best possible advice and advance warning of IT requirements, a working group was established to discuss IT issues. The group comprises at least one member from each team and meets regularly to review the specific needs and interests with regard to IT.

Completed projects include:

- Integrating the membership database with our accounting software. This enabled efficient electronic invoicing and effortless, immediate payment methods resulting in 80% of those who pay their membership annually utilising these options.
- Migration of the membership database to *SQL Server* allowing further development of our online membership services and ongoing improvements within the database including multi-user remote access.
- Utilising *Campaign Monitor* to improve external e-communications.
- Internal systems upgrade to Windows 10/Office 16 and Office 365 (email).

Job vacancies online (jobs.asms.nz)

The vacancies section of the website advertises a comprehensive listing of senior hospital doctor and dentist job vacancies in New Zealand. Average listings on the site at any one time is 30 and the vacancies section has over 1,000 visits every month. Most DHBs are now making use of our job advertising facilities and we have seen a rise in advertising from other employers.

Other matters

Potential website risk/exposure

Early in 2016 it was discovered that a commissioned modification to the functioning of the Association's website had inadvertently led to a breakdown in the security of the 'Executive-only' section. The effect of this unfortunate event had the potential to allow public access to all PDF documents that were posted on the website at the time. The entire Executive-only section was promptly removed and the national office worked swiftly and closely with their website provider to determine the magnitude of the potential exposure and mitigate risks. It was concluded that a very small number of documents were potentially at risk, and the national office is satisfied that these were not accessed.

Review of Incorporated Societies Act

The Association, along with other unions, is registered under the Incorporated Societies Act 1908. Arising out of a review by the Law Commission, this Act is now being reviewed by the Ministry of Business, Innovation & Employment which has issued a draft parliamentary bill for discussion. Senior Industrial Officer Henry Stubbs reported on the draft bill to the April meeting of the National Executive. Much of the Association's constitution appears to comply with the possible changes but may need to be reviewed in respect to disputes between members and disposal of assets in the event of winding up or dissolution.

Minister of Health's Annual Letter of Expectations to DHBs

Each year the Minister of Health sends all DHB chairs a 'Letter of Expectations'. The letter for the 2016-17 year focused on the New Zealand Health Strategy, 'living within our means', national health targets, working across government, obesity, shifting and integrating services, and the health information technology programme. The National Executive was disappointed that for the first time for many years there was no reference to the importance of clinical leadership. The Association wrote to the Minister of Health outlining this concern but received an unsatisfactory reply.

Trans Pacific Partnership Agreement

The TPPA was a major activity for the Association in 2015. This year our main activity was a submission to the Foreign Affairs, Defence and Trade Select Committees considering the Agreement. Owing to an unreasonably short timeframe, the Association's submission was limited to the undemocratic process for decision-making in the Agreement impacting on access to health care, the potential for multinational companies to compete with DHBs to provide health services, and the effects on public health measures such as tobacco control. The National Executive acknowledged the quality of the submission, especially given the circumstances.

Medical Protection Society

The Association has continued our close working relationship with the Medical Protection Society, including working together on several cases where our respective roles overlap or intersect. Much of this involves our industrial officers working with the MPS representatives and lawyers on specific cases which have been to the benefit of members. The Executive Director met with the Chief Executive of MPS while in London in May. MPS has also agreed to continue (and increase) its sponsorship of the Conference dinner.

Surveying DHBs' senior medical staff superannuation entitlements

The Association has been surveying the uptake of superannuation at DHBs for some years. The origins of this survey go back to the campaign for an employer superannuation subsidy during the 1990s. This campaign culminated in a provision for a 6% employer contribution in the first MECA being made available to all members working at DHBs.

As at 1 July 2016, DHBs reported 91.3% of all specialists and medical and dental officers combined were receiving some form of superannuation, with 266 enrolled under the NPF or GSF scheme (a decrease of 12 from 2015), 4336 receiving the 6% employer contribution under the MECA (an increase of 116 from previous year) and only 4 individuals receiving an employer contribution in some other way (a decrease of 4 from 2015).

NZMA Specialist Council

Carolyn Fowler from the National Executive has represented the Association as an observer on the New Zealand Medical Association's Specialist Council (the NZMA also has two other councils for general practitioners and doctors-in-training). Subjects have included transparency of payments made to doctors by pharmaceutical companies, 'end of life care' and advance directives, New Zealand Health Strategy review, prescribing rights, 'specialists in the third age', and the Trans Pacific Partnership Agreement.

Employment exit survey

We continue to send the survey to members who resign. This year the survey was sent to 230 people and we received 76 responses. Five reported that they had left New Zealand, 18 had retired, 23 had taken up other medical employment in New Zealand, 10 had gone into private practice and the remainder had resigned for a variety of other reasons.

The survey has been reviewed and will continue next year using a revised format.

2017 Annual Conference

The National Executive has the authority (under Clause 10.1(a) of the Constitution) to determine the date and place of the Annual Conference. It has determined that in 2017 the Conference should be held in Wellington on 23-24 November (Thursday-Friday).

Jeff Brown
ASSOCIATION NATIONAL SECRETARY 4 November 2016